X2015-246 PRINTED: 01/10/2019
FORM APPROVED

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	02/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAVOS	2600 SOUTHWEST HOLDEN SEATTLE, WA 98126

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L 000	INITIAL COMMENTS STATE LICENSING SURVEY This state licensing survey was conducted at Navos on 2/2/2015-2/6/2015 by Lisa Sassi, RN, MN and Alex Giel, EHS. The Washington Fire Protection Bureau conducted the fire life safety survey on 2/2/2015. ASE #280K11	L 000	1. A written Plan of Correction is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHEN the correction will be completed; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance, including relevant benchmarks for success, when monitoring is part of the plan. 3. Your Plan of Correction must be returned within 10 business days from the date you receive the hard copy of Statement of Deficiencies. Your Plan of Correction is due to be mailed on March 13, 2015. 4. Return the original report with the required signatures.	
L 380	322-035.1P POLICIES-EQUIP MAINTENANCE WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and	L 380		

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L 380	Continued From page 1 services provided: (p) Cleaning, inspecting, repairing and calibrating electrical, biomedical and therapeutic equipment, and documenting actions; This Washington Administrative Code is not met as evidenced by: Based on observation, interview and review of policy and procedure, the facility failed to develop and implement policies and procedures for cleaning and maintaining care supplies and equipment. Findings: 1.a. In review of the ACCU-CHEK Aviva Blood Glucose Meter Owner's Manual (2011). on page 95 it provided a section on "Information for Healthcare Professionals." There it stated, "Healthcare Professionals: Follow the infection control procedures appropriate for your facility." On page 73 it provided instructions for cleaning the machine, including options for use of different types of antimicrobial products. 1.b. On 2/2/2015 at 3:30 PM Surveyor #1 interviewed a RN (Staff Member #2) about the routine use of glucometers for testing patient blood sugars. S/he described the testing process and stated that the equipment would then be placed into the docking station for future use. When asked if s/he cleaned the glucometer before or after patient use, s/he stated that s/he did not clean it. In follow-up at the time, a related policy could not be located. 2. On 2/3/2015 at 10:30 AM, Surveyor #1 inquired about the use of a cordless telephone located at the 3rd floor nurses station. The Hospital Unit Coordinator (Staff Member #3) stated that	L 380		

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L 380	Continued From page 2 patients requested use of the cordless phone for private phone conversation (not located in the public hallway). When asked about the telephone cleaning procedure between patient use, s/he stated that there was no procedure for cleaning the phone between patient use other than the nursing station common space wipe down with antibacterial wipes once a day which included the phone. In follow-up at that time, a related policy could not be located. 3. a. On 2/4/2015 at 9:30 AM, Surveyor #1 observed the contents of the Emergency Supply Cart and supply checklist located on the 3rd floor with the Nurse Manager (Staff Member #4.) Staff members checked the content of the cart on a daily basis to assure readiness for a medical emergency. The items on the cart were noted as follows: -the electric emergency suction machine was covered with visible dust -the packaging of 2 Yankauer suction catheters were soiled and the paper wrapping was discolored and soiled -the packaging of 2 regular suction catheters were soiled and the paper wrapping was discolored, soiled and frayed on the edges -the ambu bag was located in a plastic bag with an incomplete seal and the bag was visibly dusty and discolored -the nebulizer equipment was visibly dusty and and the packaging for tubing was discolored -the Automatic Emergency Defibrillator outer cover and actual device were visibly dusty	L 380		

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L 380	Continued From page 3 3.b. During that time when Surveyor #1 asked staff Member #4 about the state of the equipment, s/he acknowledged that it was dusty and that the packaging looked worn and soiled. S/he further stated that there was not a procedure for cleaning the emergency cart equipment and/or replacing supplies with worn and soiled packaging. Item#2- Patient-Owned Medical Equipment Findings: 1. Navos Inpatient Services Policy and Procedure: Inspection and Maintenance of Biomedical Equipment (Effective Date 4/27/2011) stated in part, "Biomedical equipment will be inspected by a qualified medical equipment preventive maintenance and repair service prior to being put into use. . ." 2. On 2/4/2015 at 10:30 AM Surveyor #2 interviewed the Director of Nursing (Staff Member #6) regarding the criteria of patient-owned medical equipment (CPAP Machine) brought into the facility. Staff Member #6 stated in part that they did not have a policy in place for patient-owned equipment.	L 380		
L 390	322-035.1R POLICIES-PATIENT TRANSFER WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and	L 390		

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L 390	Continued From page 4 services provided: (r) Transferring patients to other health care facilities or agencies; This Washington Administrative Code is not met as evidenced by: Based on review of policy and procedure, record review and interview, the facility failed to implement policies and procedures for patient transfers. Findings: 1. Review of facilities policy and procedures related to patient transfer indicated the following: -"Therapeutic Transfer of A Patient to Another Facility for Psychiatric Treatment" (Effective 06/29/2009) provided direction related to transferring a patient to a specific acute care hospital that provided psychiatric services and instructed staff to send a "Patient Transfer Form" with the patient. -"Transfer of Medically Compromised Patients" (Effective 07/07/2007) under item 5.c. it instructed staff to provide the receiving facility with an "Inter-Hospital Transfer Authorization Form." Again, a specific facility was identified as the destination for this type of transfer. -"Medical Staff Documentation" (Effective 09/30/2009): there was no reference to responsibilities related to documentation for patient transfers to other facilities. -"Navos Organized Medical Staff Rules and Regulations" (revised 10/12/2011): there was no reference to responsibilities related to patient transfers to other facilities.	L 390		

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L 390	Continued From page 5 2. During review of medical records the following omissions were noted: a. Patient #7 was 15 years old and admitted on 1/24/2015 for treatment of psychosis. S/he was transferred to another psychiatric facility (other than the one listed in the policy) on 1/31/2015 for care due to her/his age. The record did not contain evidence that a patient transfer form was completed per policy. b. Patient #8 was 52 years old and admitted for paranoid schizophrenia on 12/22/2014. On 12/27/2014 s/he was transferred to another facility for evaluation of acute medical symptoms, including bloody vomit. The record did not contain evidence that a patient transfer form was completed per policy. Additionally, there was no indication in the medical record that the receiving facility was contacted by a staff member at the sending facility prior to executing the transfer. c. Patient #9 was 79 years old and admitted for treatment of bipolar disorder on 1/24/2015. The patient was transferred to another facility for declining mental status on 2/2/2015. The record did not contain evidence that a patient transfer form was completed per policy. 3. On 2/4/2015 at 11:30 AM, during an interview between Surveyor #1 and a Nurse Manager (Staff Member #11), s/he confirmed with the Director of Nursing (Staff Member #6) that an interfacility transfer form was not available at the facility for staff use.	L 390		
L 690	322-100.1A INFECT CONTROL-P&P	L 690		

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L 690	Continued From page 6 WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (a) Written policies and procedures describing: (i) Types of surveillance used to monitor rates of nosocomial infections; (ii) Systems to collect and analyze data; and (iii) Activities to prevent and control infections; This Washington Administrative Code is not met as evidenced by: Based on observation and review of policy and procedure, the facility failed to implement its' hand hygiene policy. Findings: 1. In review of facility policy titled, "Hand Hygiene" (Effective Date: March 18, 2011) in the section titled policy, it stated that staff "shall clean their hands according to the following times", including but not limited to, "After...blowing or wiping the nose or mouth" and "before preparing or serving food or beverages." It did not identify before preparing or administering medications as a time for hand hygiene. In another section titled, "Procedure" under item C it stated, "Wash hands after contact with a patient's intact skin" and item D it stated "Wash hands after contact with ...mucous membranes. " In the policy titled "Medication Administration-Oral Medications", under "Equipment" it listed "Antimicrobial agent for hand hygiene" but did not reference in the procedure section.	L 690		

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L 690	Continued From page 7 2. The following omissions in hand hygiene were noted as follows: a. On 2/2/2015 at 12:45 PM, Surveyor #2 observed a court transporter (Staff member #7) was noted to be located inside of the 3rd floor nurses station. The transporter placed her/his index finger around and inside of one nostril and, without doing hand hygiene, s/he proceeded to use that hand to grab the door handle of the nurses station and exit onto the unit. Other staff subsequently touched the same door handle. b. On 2/2/2015 at 2:35 PM,Surveyor #2 observed a RN (Staff Member #8) administer medications to 5 patients on the 2nd floor from inside the medication room. The nurse was observed for 4 minutes prior to the actual administration time when s/he went in and out of the medication room to the nurses station several times and s/he also handled medical records. During that time period and immediately prior to and during patient medication administration (including serving beverages), s/he did not perform hand hygiene. During the medication administration time period, s/he touched a patient's identification armband and used the computer keyboard intermittently. After she completed the administration s/he repositioned the carpet on the floor of the medication room and then exited the medication room (touching the door handle) to the report room to find another staff member (to witness medication wasting) without performing hand hygiene at any time. In a subsequent interview at that time s/he stated that s/he only used hand sanitizer if s/he "touched a pill."	L 690		

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L 690	Continued From page 8 c. On 2/2/2015 at 3:15 PM during shift to shift report on the 2nd floor, Surveyor #2 observed Mental Health Specialist (Staff Member #9) biting her/his fingernails several times (5 or more). The fingernails were bitten over halfway down from the top of the nail bed to the cuticle. During that time the staff member's hands came in contact with a pen and a piece of paper for patient medical information notetaking (used for reference during her/his work shift). Staff Member #9 was not observed to perform hand hygiene subsequent to her/his hands coming in contact with oral secretions after several episodes over a period of greater than 20 minutes.	L 690		
L 710	322-100.1D INFECT CONTROL-PHYS ENVIRON WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (e) A procedure to monitor the physical environment of the hospital for situations which may contribute to the spread of infectious diseases; This Washington Administrative Code is not met as evidenced by: Based on observation,interview and review of hospital's policy and procedures, the facility failed to establish and implement an infection control policy and procedure that would ensure patients would have an environment that would not contribute to the spread of infectious diseases. Findings:	L 710		

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L 710	Continued From page 9 1. On 2/3/2015 at 11:00 AM during a tour of patient's rooms Surveyor #2 observed soiled bed linen in patients' with the Environmental Service Manager (Staff Member #12), Surveyor #2 observed soiled bed linen in a patient's room; #314. The staff member stated, in part, "that they only change the linen upon patient's request". 2. On 2/3/2015 at 4:00 PM Surveyor#2 reviewed the hospital's policy and procedure titled, "Navos Organization Wide Policy and Procedure Subject: Housekeeping Supervision/Contract Oversight." (Effective Date March 18, 2011). It stated that the following are required activities for the supervisor: "Conducts routine infection control walkthrough inspections to identify quality of service and utilization of infection control interventions". In the "Task Description" it further stated, "Clean discharged patient rooms as needed. Strip and make beds at this time 7 days a week". It also stated, "Twice daily remove dirty linen and place in designated areas".	L 710		
L 780	322-120.1 SAFE ENVIRONMENT WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors; This Washington Administrative Code is not met as evidenced by: Based on observation and review of hospital's policy and procedures, the hospital failed to provide a safe and clean environment for patients, staff and visitors of the facility. Findings:	L 780		

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L 780	Continued From page 10 Item #1- Environment of Care 1. In review of the hospital's policy and procedure titled, "Housekeeping Supervision/Contract Oversight" (Effective Date March 18, 2011), section "B." stated the following are required activities for the supervisor: under Item 2, it stated, "During the infection control walkthroughs also monitor the status of the patinet care environment such as loose molding, metal HVAC delivery system and sprinkler head." 2. On 2/2/2015 at 1:00 PM Surveyor #2 observed holes in the wall in patient's bathroom #208. This was confirmed by environmental services manager (Staff Member #12). 3. On 2/2/2015 at 1:30 PM Surveyor #2 observed plywood board covering holes in the wall near the hallway telephone. This was confirmed by Nurse Manager (Staff Member #11). 4. On 2/3/2015 at 11:00 AM Surveyor #2 observed plywood board covering holes in the bathroom of patient's room #314. This was confirmed by environmental services manager (Staff Member #12). Item #2- Restroom Cleaning 1. In review of hospital's policy and procedure titled, "Housekeeping Supervision/Contract Oversight" (Effective Date March 18, 2011) under "Task Descriptions" it stated, "Wipe Clean Shower Curtains. If soiled, notify staff to replace, also dust and spot clean partitions". Both tasks were to be completed on a daily basis. 2. On 2/3/2015 at 11:00 AM, Surveyor #2	L 780		

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L 780	Continued From page 11 observed a daily clean of a patient room #314. The housekeepers (Staff Member #13 and #14) cleaned the patient's floor and restroom. Surveyor #2 found that the shower curtain which separated the patient sleeping quarters and restroom was soiled. The environmental service manager (Staff Member #12) stated, in part, "that they get cleaned once a week."	L 780		
L 795	322-120.4 VENTILATION WAC 246-322-120 Physical Environment. The licensee shall: (4) Provide natural or mechanical ventilation sufficient to remove odors, smoke, excessive heat and condensation from all habitable rooms; This Washington Administrative Code is not met as evidenced by: Based on observation the facility failed to provide sufficient ventilation to remove noxious odors from the patients' shower room. Findings: On 02/04/2015 at 9:30 AM, Surveyor #2 observed a fan in shower room #326 with excessive build-up of dust and other contaminants. The ventilation was not sufficient enough to remove strong odors in the bathroom. At the time, this finding was confirmed by the Vice President of Trauma-Informed Care (Staff Member #15). THIS FINDING IS A REPEAT CITATION.	L 795		
L1125	322-170.3G RT SERVICES WAC 246-322-170 Patient Care	L1125		

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L1125	Continued From page 12 Services. (3) The licensee shall provide, or arrange for, diagnostic and therapeutic services prescribed by the attending professional staff, including: (g) Recreational therapy services coordinated and supervised by a recreational or occupational therapist with experience working with psychiatric patients, responsible for integrating recreational therapy functions into the comprehensive treatment plan; This Washington Administrative Code is not met as evidenced by: Based on review of facility documents, interview and record review, the facility failed to demonstrate that recreational therapy services and functions were integrated into the patients' comprehensive treatment plans. Findings: 1. In review of the Adjunctive Therapies Director job description item II.P. stated, "Complete Adjunctive therapies Treatment Planning when applicable." 2. On 2/3/2015 at 12:30 PM Surveyor #1 interviewed the Adjunctive Therapy Director (Staff Member #10) and s/he stated that there were a total of 4 staff persons assigned to provide adjunctive therapies to patients. S/he indicated that adjunctive therapists aimed to involve most patients in different forms of therapy including, but not limited to, art and dance therapy. S/he indicated that all of the adjunctive therapists were licensed health providers. When asked if the adjunctive therapists	L1125		

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L1125	Continued From page 13 developed and implemented services into the patients' comprehensive treatment plans, s/he stated they did not routinely make treatment plan entries and were not routinely involved in clinical reviews of treatment plan. The adjunctive therapists made individual progress note entries even though the treatment plan provided specific areas for adjunctive therapy entries. Also, s/he stated that the manner in which treatment plan reviews were conducted did not make it possible for adjunctive therapist participation at the treatment plan reviews. 3. In review of medical records the following was noted related to treatment plan integration: a. Patient #4 was 37 years old and admitted on 3/17/2014 for treatment of bipolar disorder and psychotic symptoms. After an initial treatment plan was developed on 3/19/2014, s/he had a treatment plan review on 3/26/2014, 4/2/2014, 4/4/2014, 4/10/2014, 4/16/2014 and 4/23/2014 which comprised a total of 30 pages. There was no documentation of adjunctive therapy services integration into the comprehensive treatment plan and reviews. b. Patient #5 was 42 years old and admitted on 5/13/2014 for schizoaffective disorder. After an initial treatment plan was developed on 5/13/2014, s/he had a treatment plan review on 5/22/2014, 5/29/2014, 6/5/2014, 6/12/2014, 6/19/2014 and 6/27/2014 which comprised a total of 35 pages. There was no documentation of adjunctive therapy services integration into the comprehensive treatment plan and reviews. c. Patient #6 was 44 years old and admitted on 10/30/2014 for treatment of psychosis and possible schizoaffective disorder. After an initial	L1125		

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L1125	Continued From page 14 treatment plan was developed on 10/30/2014, s/he had a treatment plan review on 11/10/2014, 11/17/2014, 11/17/2014, 11/24/2014 and 12/1/2014 which comprised a total of 25 pages. There was no documentation of adjunctive therapy services integration into the comprehensive treatment plan and reviews.	L1125		
L1165	322-180.2 EMERGENCY SUPPLIES WAC 246-322-180 Patient Safety and Seclusion Care. (2) The licensee shall provide adequate emergency supplies and equipment, including airways, bag resuscitators, intravenous fluids, oxygen, sterile supplies, and other equipment identified in the policies and procedures, easily accessible to patient-care staff. This Washington Administrative Code is not met as evidenced by: Based on review of policy and procedure, interview and observation, the facility failed to demonstrate that it provided adequate emergency supplies and equipment. Findings: 1. In review of facility policy titled, "Emergency Medical Equipment" (Revised 2/7/13) that guided the staff actions during acute medical emergencies and when physicians were not present, the required equipment was listed. The equipment list did not include intravenous solutions and it did include an "oral airway."	L1165		

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	007470	A. BUILDING: _____ B. WING _____	02/06/2015

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L1165	Continued From page 15 2. On 2/3/2015 at 2:15 PM Surveyor #1 interviewed a pharmacist (Staff Member #5) about the availability of intravenous fluids for emergency administration. S/he stated that s/he has preliminarily initiated a process for obtaining intravenous fluids. However, the facility had not yet stocked those supplies on site and it was not part of the nursing responsibilities to start intravenous lines for fluid administration. 3. On 2/4/2015 at 9:30 AM, Surveyor #1 reviewed the contents of the Emergency Supply Cart and checklist located on the 3rd floor with the Nurse Manager (Staff Member #4). Staff members checked the content of the cart on a daily basis to assure readiness for a medical emergency. However, it was noted that an oral airway device was not included on the master supply list or on the cart that contained other emergency supplies to ensure adequate breathing. This finding was acknowledged by Staff Member #4.	L1165		
L1315	322-200.4C RECORDS-AUTHENTICATION WAC 246-322-200 Clinical Records. (4) The licensee shall ensure each entry includes: (c) Authentication by the individual making the entry; This Washington Administrative Code is not met as evidenced by: Based on review of policy and procedure and record review the facility failed to ensure authentication of telephone verbal orders used to place patients in restraints and/or seclusion. Findings: 1. In review of facility policy and procedure titled,	L1315		

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L1315	Continued From page 16 "Seclusion and Restraint" (Revised 4/23/2013) on page 2 item 4 stated, "The initial order may be a telephone order. Telephone orders must be countersigned by the ordering physician within 48 hours. 2. Review of patient medical records identified the following omissions: a. Patient #1 was 37 years old and admitted for treatment of schizoaffective disorder on 3/17/2014. A telephone order for mechanical restraint placement was obtained on 4/3/2014 at 10:45 AM. The order was countersigned 5 days later on 4/8/2014 at 11:55 AM. b. Patient #2 was 68 years old and admitted for treatment of bipolar disorder on 2/14/2014. A telephone order for 4 point mechanical restraint placement was obtained on 4/4/2014 at 5:00 PM. The order was countersigned 3 days later on 4/7/2014 at 1:06 PM. c. Patient #3 was 40 years old and admitted for treatment of a paranoid schizophrenia disorder on 4/21/2014. A telephone order for restraint placement was obtained on 4/21/2014 at 6:30 PM. The order was countersigned several weeks later on 5/7/2014 at 10:54 AM. The same patient had another telephone order for 4 point mechanical restraint placement obtained on 4/25/2014 at 5:45 AM. The order was countersigned several weeks later on 6/3/2014 at 11:24 AM.	L1315		
L1485	322-230.1 FOOD SERVICE REGS WAC 246-322-230 Food and Dietary	L1485		

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L1485	Continued From page 17 Services. The licensee shall: (1) Comply with chapters 246-215 and 246-217 WAC, food service; This Washington Administrative Code is not met as evidenced by: Based on observation and interview, the facility failed to comply with chapters 246-215, Washington Administrative Code (WAC) for food service. Findings: On 2/2/2015 at 11:45 AM Surveyor #2 observed soiled residue in the juice dispenser nozzles in both kitchens on the 2nd and 3rd floor. To prevent contamination of product, nozzles must be clean to preclude accumulation of soil residue. Reference: Washington State Retail Food Code, WAC 246-215-5605(5)(d) On 2/4/2015 at 9:00 AM Surveyor #2 observed the small food refrigeration units on the 2nd and 3rd floor medication rooms had malfunctioning cold holding devices. The temperature logs for both refrigerator units indicated temperatures in the below freezing range 20-28 degrees Fahrenheit from 1/1/2015 to 1/31/2015 on the second floor and 26-35 degrees Fahrenheit from 1/1/2015-1/31/2015 on the 3rd floor. Surveyor #2 used a thin stem probe thermometer and found that the temperature on the 2nd floor tempted at 34.7 degrees Fahrenheit and the temperature on the 3rd floor tempted at 41.7 degrees Fahrenheit. To ensure temperature is in compliance of Washington State Retail Food Code, measuring devices must be accurate to + or - 3 degrees Fahrenheit in the intended range of use.	L1485		

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L1485	Continued From page 18 Reference: Washington State Retail Food code, WAC 246-215-04220(2)	L1485		